CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 552

Department of Health & Human Services
Center for Medicare and &
Medicaid Services
Date: APRIL 29, 2005
Change Request 3825

SUBJECT: Changing the Order of Medicare System Edits Affecting Hospice Claims

I. SUMMARY OF CHANGES: This transmittal revises Medicare systems so that edits that enforce sequential billing on hospice claims will be moved from their current position prior to the medical review process to a position after all medical review edits.

NEW/REVISED MATERIAL :
EFFECTIVE DATE : Claims received on or after October 1, 2005
IMPLEMENTATION DATE : October 3, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED

R/N/D	Chapter / Section / Subsection / Title
R	1/50.2.3/Submitting Bills In Sequence for a Continuous Inpatient Stay or Course of Treatment

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

****Unless otherwise specified, the effective date is the date of service.***

Attachment - Business Requirements

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SUBJECT: Changing the Order of Medicare System Edits Affecting Hospice Claims

I - GENERAL INFORMATION

A. - Background: Claims for hospice services are required to be processed in sequence by date of service. This requirement, known as 'sequential billing', is essential to the efficient processing of Medicare hospice claims. Hospice claims must be matched by Medicare systems to the appropriate 90-or 60-day hospice benefit period in order to be paid. Without sequential billing, accurate matching of claims to benefit periods would often require the manual cancellation and reprocessing of numerous claims, resulting in increased costs to the Medicare program and unpredictable disruptions to hospice providers' account receivable.

Despite its overall benefit to consistency of claims payment, sequential billing may delay payment when claims are suspended for medical review. While one claim is awaiting or undergoing review, later dated claims for the same beneficiary are held and recycled daily, awaiting the release and payment of the claims in review. This delay is greatest when all claims for a beneficiary or for the hospice will be subject to review. While medical records for one claim have been requested (a period of up to 45 days), the next claim for the same beneficiary is held at a very early stage of Medicare processing. Once the first claim is reviewed and finalized, this next claim is released and again triggers a request for records. During the period while these records are prepared and reviewed, a third claim for the beneficiary may be received (if it was not already received and held) and a fourth, etc.

Responding to the requests of hospices to provide relief from these delays, CMS has determined that Medicare systems can be revised to decrease them. The edits in Medicare systems are themselves sequential, firing in a predetermined order. This order will be changed. As of the effective date below, the edits that enforce sequential billing will be moved from their current position prior to the medical review process to a position after all medical review edits. As a result, any hospice claim that will be subject to review will trigger a request for records immediately upon receipt, rather than being held while previous record requests are being processed. By making the record request and review periods for multiple hospice claims simultaneous, delays to hospice claims may be reduced. Once released from medical review, if a claim is found to be out of sequence it will be held at that later point, when record request delays no longer affect it.

B. Policy: The requirement for hospice claims to be submitted in sequence is found in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 1, section 50.2.3. Instructions published in transmittal A-99-21, dated July 1999 stated that hospice claims found to be out of sequence should in many cases be held and recycled rather than rejected.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (place an “X” in the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3825.1	Medicare systems shall revise edits enforcing sequential billing in any driver or module prior to medical review to no longer apply to hospice claims (types of bill 81x and 82x).					X				
3825.2	Medicare systems shall install a new edit enforcing sequential billing in a driver or module subsequent to medical review. The edit shall be specific to hospice claims (types of bill 81x and 82x).					X				

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: Hospice benefit periods may need to be created on test beneficiary records to facilitate testing. After these changes are implemented in a test region, several series of hospice test claims will be required in order to ensure that processing of claims both in sequence and out of sequence are successful.

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: Claims received on or after October 1, 2005 **Implementation Date: October 3, 2005** **Pre-Implementation Contact(s):** Kelly Buchanan – 410-786-6132; Wil Gehne- 410-786-6148 **Post-Implementation Contact(s):** Appropriate regional office	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.**

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50.2.3 - Submitting Bills In Sequence for a Continuous Inpatient Stay or Course of Treatment

(Rev. 552, Issued: 04-29-05, Effective: 10-01-05, Implementation: 10-03-05)

When a patient remains an inpatient of a SNF, TEFRA hospital or unit, swing-bed, or hospice for over 30 days, these providers submit a bill every 30 days. (See §50.2.2 for Frequency of Billing.) Claims for the beneficiary are to be submitted in service date sequence. The shared system must edit to prevent acceptance of a continuing stay claim or course of treatment claim until the prior bill has been processed. If the prior bill is not in history, the incoming bill will be returned to the provider with the appropriate error message.

When an out-of-sequence claim for a continuous stay or outpatient course of treatment is received, FIs will search the claims history for the prior bill. They do not suspend the out-of-sequence bill for manual review, but perform a history search for an adjudicated claim. For bills other than hospice bills, if the prior bill is not in the finalized claims history, they return to the provider the incoming bill with an error message requesting the prior bill be submitted first, if not already submitted. The returned bill may only be resubmitted after the provider receives notice of the adjudication of the prior bill. A typical error message would be as follows:

> Bills for a continuous stay or admission or for a continuous course of treatment must be submitted in the same sequence in which the services are furnished. If you have not already done so, please submit the prior bill. Then, resubmit this bill after you receive the remittance advice for the prior bill.

For a hospice claim that is out of sequence, the FI searches their claims history. If the FI finds the prior claim has been received but has not been finalized (for instance, it has been suspended for additional development), they do not cause the out of sequence claim to be returned to the provider. Instead, they hold the out of sequence claim until the prior claim has been finalized and then process the out of sequence claim. If the prior hospice claim has not been received, the out of sequence hospice claim is returned to the provider with an error message as described above. *FIs shall perform editing to ensure hospice claims are processed in sequence after any necessary medical review of the claims has been completed.*

Since hospice claims received out of sequence do not pass all required edits, they do not meet the definition of “clean” claims defined in §80.2 below. As a result, they are not subject to the mandated claims processing timeliness standard and are not subject to interest payments. FIs will enter condition code 64 on the out of sequence claims they are holding when awaiting the processing of the prior claims to indicate that they are not “clean” claims.